The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, 503-238-6961 or 1-866-230-6313. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 503-238-6961 or 1-866-230-6313 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200/individual or $600/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care, primary care, and emergency room services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: $1,200/indiv. in-network; $1,700/indiv. out-of-network. Prescription: $1,000/indiv.I in-network; $1,500/indiv. out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, copayments on certain services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. Call 1-800-768-4695 or 1-800-768-4695 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment; deductible does not apply	30% coinsurance	None
	Specialist visit	$20 copayment; deductible does not apply	30% coinsurance	Physical therapy must be prescribed by a physician.
	Preventive care/screening/ immunization	$20 copayment; deductible does not apply. ($0 copay if qualifies as preventive exam)	Not covered	Adult immunizations and immunizations solely for foreign travel or foreign residence are not covered. Some services will include frequency limits. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kpp-rx.com	Generic drugs	Retail: 10% coinsurance with $10 minimum. Mail-order and Option 90: $20 copayment.	Retail: 15% coinsurance with $15 minimum. Mail-order: not covered.	Not all prescription drugs are covered and some prescription drugs require prior authorization. To determine if a drug is covered or requires prior authorization, e-mail Kroger at rxplans@kroger.com or call 1-800-482-1285. Retail: in-network retailers are limited to Fred Meyer, QFC, Safeway, Lower Umpqua Hospital Pharmacy, and Reedsport Pharmacy. Option 90 (90-day supply from retail): in-network retailers are limited to Fred Meyer and QFC.
	Preferred brand drugs	Retail: 10% coinsurance with $20 minimum. Mail-order and Option 90: $40 copayment.	Retail: 15% coinsurance with $25 minimum. Mail-order: not covered.	
	Non-preferred brand drugs	Retail: 20% coinsurance with $40 minimum. Mail-order and Option 90: $80 copayment.	Retail: 25% coinsurance with $45 minimum. Mail-order: not covered.	
	Specialty drugs	Same cost as for generic, preferred, and non-preferred brand drugs, as applicable.		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Must be recommended and approved by physician. Private duty nursing care is not covered.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$100 copayment then 20% coinsurance; deductible does not apply	$100 copayment then 30% coinsurance; deductible does not apply	Copayment is waived if directly admitted to hospital.
	Emergency medical transportation	20% coinsurance	30% coinsurance	Limited to continental U.S., Hawaii, Puerto Rico, and Canada. Air ambulance limited to nearest hospital qualified to give the treatment.
	Urgent care	$50 copayment; deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Must be authorized by a physician.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment; deductible does not apply	30% coinsurance; deductible does not apply	Coverage only for MD, DO, psychologist, licensed clinical social worker, or licensed counselor.
	Inpatient services	20% coinsurance	30% coinsurance	None
If you are pregnant	Office visits	$10 copayment; deductible does not apply	30% coinsurance	Dependent children's pregnancy expenses are not covered.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Limited to services of registered professional nurse who is not related to the patient.
	Rehabilitation services	20% coinsurance	30% coinsurance	None
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	30% coinsurance	Services must begin within 14 days of the patient's release from a hospital stay that is at least three days long. Maximum of 120 days per confinement less the days hospitalized.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance	30% coinsurance	None
	Hospice services	No charge	No charge	Physician must certify the patient is terminally ill with six or fewer months to live.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to one exam per 12-month period.
	Children's glasses	Standard lenses: no charge. Frames: costs above $130 or Contact lenses: costs above $155 + $60 exam copayment	Lenses: costs above $50/$75/$100 by type. Frames: costs above $70 or Contact lenses: costs above $155	Lens limit: one per 12-month period. Frame limit: one per 24-month period. Go to www.vsp.com or call 800-877-7195 for list of network vision providers.
	Children's dental check-up	$50/individual and $150/family calendar-year deductible then 20% coinsurance		Oral exams and bitewing x-rays are limited to two each calendar year. Full mouth x-rays are limited to once every five-year period.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside U.S.
- Pregnancy expenses of dependent children
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (26 maximum visits every six months; spinal manipulation only; dependents covered only to treat accidental injury)
- Dental care (Adult)
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Trust Administrator at 503-238-6961 or 1-866-230-6313.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 866-230-6313.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-230-6313.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**866-230-6313.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866-230-6313.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$200
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$100
Coinsurance	$1000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,200**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$200
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other copayment	$10

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$200
Coinsurance	$1000
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,320**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$200
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$120
Copayments	$80
Coinsurance	$340
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$540**

The plan would be responsible for the other costs of these EXAMPLE covered services.